



## MORBIDITY AND MORTALITY WEEKLY REPORT

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*Epidemiologic Notes and Reports*

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### **Self-Reported Behavioral Change Among Gay and Bisexual Men — San Francisco**

In August 1984 and April 1985, surveys of risk factors for human T-lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV) infections in gay and bisexual men living in San Francisco, California, were conducted (1). The surveys used a random probability sample designed to provide information about sexual practices of self-identified gay and bisexual men in San Francisco. The sample was drawn from telephone numbers listed with only male names. City census tracts were weighted according to the proportion of unmarried males residing in each tract.

Exceptional care was taken to identify appropriate respondents. Following a brief introduction about the survey, and after an assurance of confidentiality, each potential respondent was told, "We are interested in speaking with one group of people who are at highest risk for AIDS: men who have sex with other men or who identify themselves as gay or bisexual." The interviewer then asked, "... would you include yourself in one of these groups?" Those who responded positively were considered eligible and asked to participate. Among those eligible, 81.4% agreed to participate. A total of 500 men were interviewed in the August 1984 survey. In April 1985, participants from the original panel of 500 were randomly selected and telephoned. Of those contacted, 93.2% agreed to participate again for a total of 301 repeat interviews.

Results of the initial survey were used by the San Francisco AIDS Foundation to plan an educational campaign designed to encourage gay and bisexual men to avoid "unsafe" sexual practices. Practices defined as "unsafe" by the San Francisco AIDS Foundation included anal intercourse without a condom and oral sex with exchange of semen. These practices were specifically discouraged in advertisements that were placed primarily in gay newspapers.

Between August 1984 and April 1985, the proportion of gay and bisexual men who reported that they were monogamous, celibate, or performed "unsafe" sexual practices only with their steady partner increased from 69% to 81% (Table 1). Similarly, fewer gay and bisexual men reported having more than one sexual partner in the past 30 days. Similar changes also were noted for other "unsafe" sexual practices.

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**Editorial Note:** The virus that causes AIDS (HTLV-III/LAV) is spread by sexual contact, needle sharing, and parenteral exposure to blood or blood products and from mother to child during the perinatal period (2). Groups concerned about reducing the transmission of HTLV-III/LAV, such as the San Francisco AIDS Foundation, are addressing certain practices of homosexual men that appear likely to facilitate the transmission of HTLV-III/LAV. Published reports

*Gay and Bisexual Men — Continued*

have associated AIDS or HTLV-III/LAV infection with practices such as having multiple sex partners and participating in anal intercourse (3-6). Oral-genital sex has also been addressed as a practice which may facilitate virus transmission because HTLV-III/LAV has been isolated from semen (7).

The multiple and varied sources of information about AIDS and its presumed methods of transmission preclude attribution of behavioral change among homosexuals to any single source or educational intervention. The self-reported changes observed in these two telephone surveys are consistent with the aims of the campaign conducted by the San Francisco AIDS Foundation and those of similar efforts by other groups. Although the data are self reported, alterations in sexual practices appear to have occurred over a relatively short period of time.

These two surveys suggest that some gay and bisexual men in San Francisco have modified their sexual practices. They provide support for continued efforts to promote change in behaviors that may reduce transmission. However, the importance of any behavioral changes in reducing the risk within a high-risk population of acquiring AIDS must be assessed in relation to any change in the prevalence of HTLV-III/LAV infection within that population. In San Francisco, between 1978 and 1985, the prevalence of serum antibodies to HTLV-III/LAV among a selected cohort of gay men in the San Francisco City Clinic increased from 4.5% to 73.1% (8). If the prevalence of infection has increased as much among all gay and bisexual men in San Francisco, much larger changes in sexual practices will be necessary to achieve a substantial reduction of risk among those who remain uninfected. However, most communities probably have infection prevalences lower than those reported in the San Francisco cohort. In such communities, significant modification of sexual practices may have a greater effect on risk reduction. Modification of sexual practices is the main means available at present by which gay and bisexual men who are HTLV-III/LAV-antibody negative can reduce their risk of becoming infected.

Continued surveillance of behaviors that may result in the transmission of HTLV-III/LAV is essential for designing information and education campaigns and for evaluating the impact of those campaigns and may provide information permitting prediction of AIDS incidence.

**TABLE 1. Changes in selected self-reported sexual practices\* among gay and bisexual men — San Francisco, California, August 1984 and April 1985**

Practice	Survey	
	August 1984	April 1985
Monogamous, celibate, or no unsafe sexual activity outside a primary relationship. <sup>†</sup>	69%	81%
More than one sexual partner during last 30 days.	49%	36%
Anal intercourse (without a condom) with secondary partner <sup>§</sup> during past 30 days.	18%	12%
Oral sex (with exchange of semen) with secondary partners during past 30 days.	17%	7%

\*Behavior changes statistically significant at 0.05 level or less.

<sup>†</sup>For the purposes of this study, an unsafe sexual practice included anal intercourse without a condom and oral sex with exchange of semen.

<sup>§</sup>Sexual contact other than the primary partner.

*Gay and Bisexual Men — Continued**References*

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### **Rubella Outbreaks in Prisons — New York City, West Virginia, California**

From March to July 1985, three rubella outbreaks were reported among groups of inmates and staff at prisons in New York City, West Virginia, and California. A total of 93 persons were affected.

**New York City.** The largest outbreak occurred at a correctional institution in New York City, where 50 cases of clinical rubella\* were reported from March 14 through June 11. All but three patients had onset of rash on or after April 21 (Figure 1). Ten (20%) of the 50 cases were serologically confirmed as rubella. The prison is located in the same geographic area as a factory with reported rubella activity, but an epidemiologic link could not be documented.

Of the 50 patients, 42 (84%) were prison inmates, and eight (16%) were correctional staff. One 41-year-old female correctional officer in the unit where the majority of cases occurred developed rubella; the remaining 49 patients were males. Patients ranged in age from 19 years to 41 years.

The detention facility confines approximately 8,000 inmates, 600 of whom are women. Four thousand correctional officers and other personnel are employed by the detention facility. Daily admissions into the correctional system range between 150 and 250 persons, including approximately 40 women. The constant movement of inmates and accompanying staff to and from courts and the transfers of inmates to other correctional facilities create substantial potential for spread of illness.

When rubella was first suspected, isolation precautions were initiated for all symptomatic patients. Pregnant female inmates were serologically screened for rubella immunity and housed in the infirmary if found to be susceptible. After rubella infection was serologically confirmed in five inmates on April 25, the New York City Department of Health and the Montefiore Rikers Island Health Services established immunization clinics for inmates and employees at the main detention facility and five satellite facilities from April 27 to May 7. Vaccine was not offered to persons over 45 years of age. A total of 4,107 (51%) inmates and 976

\*Case definition used in this outbreak: generalized maculopapular rash and at least one of the following — fever, conjunctivitis, coryza, joint pain, lymphadenopathy, or headache.

*Rubella — Continued*

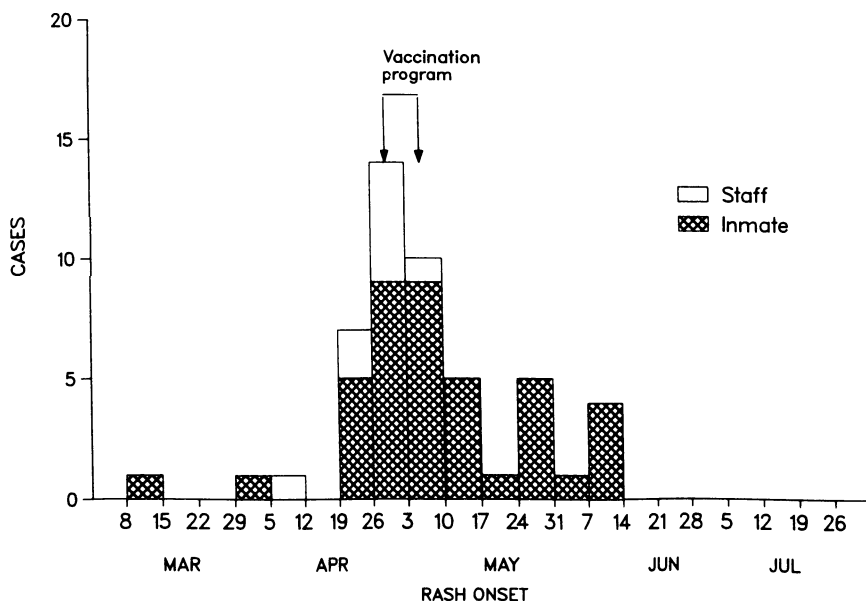
(24%) correctional staff received rubella vaccine at the clinics. In addition, a program to immunize newly admitted inmates on a daily basis continued until 21 days after onset of the last case.

**West Virginia.** From April 17 to May 6, nine cases of clinical rubella, all of which were serologically confirmed, occurred among inmates at a federal prison in Morgantown, West Virginia. Patients ranged in age from 23 years to 30 years; seven were males, and two were nonpregnant females. Immediately after diagnosing the first case on April 17, the prison physician contacted the West Virginia Immunization Program. After serologic confirmation of the first seven cases was obtained April 22, voluntary immunization of inmates and prison staff began. Three hundred two (96%) of 316 inmates and 78 (55%) of 142 prison employees who lacked written documentation of rubella immunity<sup>†</sup> were immunized. Rubella did not spread to the surrounding community.

**California.** The third rubella outbreak occurred at a county prison facility in Santa Clara County, California. Thirty-four cases occurred from April 18 to July 26, 30 among inmates and four among prison employees. One female among each of the two groups was affected. Of the 34 clinical cases, 24 (71%) were serologically confirmed. Patients ranged in age from 19 years to 35 years. The presumed index patient, a 23-year-old female file clerk, was employed in an office adjacent to the prison sick bay where she continued working during her rash illness. Control measures included isolation of active cases and of nonimmune pregnant inmates. Warnings were issued to staff and visitors who might have been pregnant. Rubella immunization of 350 persons on the correctional staff and the 230 female and 2,500 male inmates began June 21. One woman who did not know she was pregnant received rubella vaccine. Two rubella cases in nearby Santa Cruz County were epidemiologically linked to a prisoner with serologically confirmed rubella. No subsequent spread to the surrounding community was documented.

<sup>†</sup>Documented receipt of rubella vaccine on or after the first birthday or laboratory evidence of immunity.

**FIGURE 1. Rubella among prison inmates and staff, by week of rash onset — New York City, March 14,–June 11, 1985**



*Rubella — Continued*

In none of the three outbreaks was any patient known to have been previously immunized against rubella. No pregnant women were known to have contracted rubella during the outbreaks.

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**Editorial Note:** Before vaccine licensure in 1969, rubella was primarily a disease of young school-aged children, with the highest incidence rate in children 5-9 years old. However, a substantial percentage (23%) of cases was reported among persons older than 14 years (1). Since vaccine licensure, age-specific incidence rates have declined in all age groups. Initially, the decline was less marked for persons older than 15 years (2). Consequently, the occurrence of rubella among adolescents and adults became increasingly prominent as outbreaks among susceptible populations of military recruits (3), hospital personnel (4), office workers (5-7), college students (8), and, most recently, prison inmates and staff were recognized.

The goal of rubella immunization is to prevent rubella infection during pregnancy and the consequent 20%-80% risk of delivering an infant affected by congenital rubella syndrome (CRS). The severe consequences of CRS and the average lifetime cost (in excess of \$200,000) incurred by each CRS patient (9) may thus be prevented by vaccine. When rubella vaccine was first licensed, transmission of rubella was greatest among preschool and elementary school children. The initial vaccination strategy adopted by the United States was universal immunization of all young children; vaccination would protect them immediately and subsequently through their childbearing years, while greatly reducing or even interrupting circulation of the virus. By virtually eliminating the risk of exposure, susceptible pregnant women would be protected indirectly (1).

This vaccination strategy reduced the reported incidence rates of rubella in all age groups by more than 90%, but the greatest declines occurred among persons under 15 years old (1). Meanwhile, the proportion of susceptible individuals in the population of childbearing age remained fairly constant (10%-20%) (9). As a result, adolescents and adults began to account for an increasing percentage of reported cases. Since 1981, 37%-62% of rubella cases reported annually have been among persons 15 years of age or older.

The changing age distribution of reported rubella patients has been accompanied by continuing reports of sustained rubella outbreaks in settings where older adolescents and adults congregate. The reports of sustained outbreaks have led to increased efforts to vaccinate these older populations and thus hasten the elimination of CRS (1,9). However, many gaps still exist in these efforts because of the logistical problems of vaccinating nonschool-based populations.

Although they have not previously been reported, rubella outbreaks in prisons are not unexpected, given the susceptibility of groups within prisons and the closed, confined environment with its increased opportunities for transmission. Rubella outbreaks in prisons lead to disruption of orderly activities, to time lost from work, and, possibly, to breakdowns in security. Rubella outbreaks also pose a risk of infection for pregnant women inmates, staff, and visitors. To control such outbreaks, active identification and confirmation of cases, isolation of patients during the infectious period, isolation or exclusion of nonimmune pregnant women until the end of the outbreak, and vaccination of susceptible individuals are necessary.

Preventing outbreaks is preferable to controlling them. Outbreaks in prisons and other institutions where young adults congregate are likely to occur until those adults are immune. A history of previous infection is unreliable and should not be accepted as proof of immunity (10).

*Rubella — Continued*

Vaccinating susceptible persons in prisons—and the remaining susceptible adult population—would effectively reduce the risk of outbreaks. Vaccination requirements have virtually eliminated rubella among military recruits (3); similar requirements should be equally effective in other institutions. Vaccination against measles and hepatitis B could also reduce the risk of transmission of these diseases among prison inmates.

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**TABLE I. Summary—cases of specified notifiable diseases, United States**

Disease	40th Week Ending			Cumulative, 40th Week Ending		
	Oct. 5, 1985	Oct. 6, 1984	Median 1980-1984	Oct. 5, 1985	Oct. 6, 1984	Median 1980-1984
Acquired Immunodeficiency Syndrome (AIDS)	218	81	N	6,022	3,146	N
Aseptic meningitis	364	297	332	7,008	5,946	6,799
Encephalitis: Primary (arthropod-borne & unsp.)	53	37	47	868	838	1,146
Post-infectious	3	4	2	102	97	76
Gonorrhea: Civilian	15,721	17,299	20,313	643,676	639,143	737,122
Military	235	339	486	13,970	16,582	20,868
Hepatitis: Type A	486	496	496	16,968	16,084	17,387
Type B	503	540	462	19,778	19,632	16,501
Non A, Non B	70	79	N	3,145	2,873	N
Unspecified	122	92	189	4,382	3,801	6,707
Legionellosis	16	20	N	478	511	N
Leprosy	5	3	4	283	179	179
Malaria	19	27	27	777	741	851
Measles: Total*	5	11	28	2,495	2,349	2,349
Indigenous	5	8	N	2,064	2,072	N
Imported	-	3	N	431	277	N
Meningococcal infections: Total	32	34	41	1,840	2,142	2,146
Civilian	32	34	40	1,837	2,138	2,138
Military	-	-	-	3	4	14
Mumps	31	39	61	2,320	2,326	3,454
Pertussis	99	50	43	2,177	1,883	1,313
Rubella (German measles)	3	11	26	559	623	1,826
Syphilis (Primary & Secondary): Civilian	452	525	617	19,560	21,501	23,508
Military	2	5	3	118	241	289
Toxic Shock syndrome	8	15	N	277	381	N
Tuberculosis	406	406	474	16,285	16,311	19,462
Tularemia	6	8	6	129	249	218
Typhoid fever	17	7	9	281	261	334
Typhus fever, tick-borne (RMSF)	21	12	13	601	738	1,029
Rabies, animal	88	90	105	4,114	4,183	4,943

**TABLE II. Notifiable diseases of low frequency, United States**

	Cum. 1985		Cum. 1985
Anthrax	-	Leptospirosis (Calif. 1)	29
Botulism: Foodborne (Wash. 1)	40	Plague	11
Infant	46	Polioimyelitis: Total	4
Other	1	Paralytic	4
Brucellosis (Mich. 1, Mo. 1, Ark. 1, Tex. 1, Calif. 1)	110	Psittacosis (Calif. 1)	85
Cholera	3	Rabies, human	-
Congenital rubella syndrome	-	Tetanus (Pa. 1, Calif. 1)	50
Congenital syphilis, ages < 1 year	111	Trichinosis (Alaska 1)	51
Diphtheria	1	Typhus fever, flea-borne (endemic, murine) (N.Y. City 1)	20

\*There were no cases of internationally imported measles reported for this week.

**TABLE III. Cases of specified notifiable diseases, United States, weeks ending  
October 5, 1985 and October 6, 1984 (40th Week)**

Reporting Area	AIDS Cum. 1985	Aseptic Mening- itis 1985	Encephalitis		Gonorrhea (Civilian) Cum. 1985    Cum. 1984		Hepatitis (Viral), by type				Legionel- losis 1985	Leprosy Cum. 1985
			Primary	Post-in- fectious			A	B	NA,NB	Unspec- ified		
			Cum. 1985	Cum. 1985			1985	1985	1985	1985		
UNITED STATES	6,022	364	868	102	643,676	639,143	486	503	70	122	16	283
NEW ENGLAND	208	23	22	-	17,637	17,454	19	34	2	6	-	6
Maine	10	-	-	-	861	755	-	-	-	-	-	-
N.H.	-	4	5	-	431	543	-	1	1	-	-	-
Vt.	1	5	-	-	258	289	1	1	1	-	-	-
Mass.	128	10	15	-	7,134	7,285	4	18	-	6	-	6
R.I.	10	2	-	-	1,427	1,221	1	-	-	-	-	-
Conn.	59	2	2	-	7,526	7,361	13	14	-	-	-	-
MID ATLANTIC	2,393	50	108	11	97,499	86,226	27	38	1	3	-	31
Upstate N.Y.	276	19	34	4	13,669	13,568	17	14	1	2	-	1
N.Y. City	1,625	12	12	-	47,406	34,297	1	-	-	-	-	26
N.J.	351	19	26	-	15,017	14,968	-	-	-	-	-	-
Pa.	141	-	36	7	21,407	23,393	9	24	-	1	-	4
E.N. CENTRAL	255	79	233	20	90,620	89,754	12	39	4	5	6	21
Ohio	43	43	102	4	23,462	23,070	5	16	2	1	1	3
Ind.	19	8	53	2	9,898	10,022	3	11	1	1	5	-
Ill.	131	-	14	8	22,549	20,461	-	-	-	-	-	16
Mich.	44	28	45	-	25,840	26,229	4	12	1	3	-	2
Wis.	18	-	19	6	8,871	9,972	-	-	-	-	-	-
W.N. CENTRAL	75	8	64	3	31,624	31,502	17	10	5	1	2	2
Minn.	21	6	30	1	4,698	4,760	1	1	1	-	-	1
Iowa	10	-	23	-	3,387	3,432	-	1	-	-	1	-
Mo.	33	2	-	-	15,259	15,164	1	7	4	1	1	1
N. Dak.	-	-	-	1	211	293	-	-	-	-	-	-
S. Dak.	1	-	-	-	617	724	12	-	-	-	-	-
Nebr.	2	-	5	-	2,690	2,252	3	1	-	-	-	-
Kans.	8	-	6	1	4,762	4,877	-	-	-	-	-	-
S. ATLANTIC	930	54	102	39	142,346	161,811	25	88	18	5	2	7
Del.	10	8	5	-	3,360	2,945	-	-	-	-	-	-
Md.	105	8	22	1	22,606	18,823	2	20	5	-	-	1
D.C.	138	-	-	-	11,904	11,555	-	-	-	-	-	-
Va.	77	8	22	6	14,803	15,380	3	5	-	-	2	-
W. Va.	5	7	23	-	2,049	2,050	-	1	-	1	-	-
N.C.	46	6	25	1	27,599	26,322	2	16	4	2	-	2
S.C.	24	4	5	-	16,949	16,564	-	10	1	-	-	-
Ga.	138	1	-	-	-	29,668	2	9	2	-	-	1
Fla.	387	12	-	31	43,076	38,504	16	27	6	2	-	3
E.S. CENTRAL	52	32	26	4	57,391	56,601	2	30	3	7	-	-
Ky.	13	2	8	-	6,676	6,734	1	9	-	2	-	-
Tenn.	15	19	6	-	21,995	23,402	1	5	-	4	-	-
Ala.	21	8	10	4	17,312	17,727	-	14	1	-	-	-
Miss.	3	3	2	-	11,408	8,738	-	2	2	1	-	-
W.S. CENTRAL	447	47	107	2	85,822	87,252	73	53	6	20	-	18
Ark.	5	2	3	1	8,331	7,981	2	5	1	1	-	1
La.	72	2	3	-	16,519	19,380	7	3	1	3	-	1
Okla.	13	4	23	1	9,543	9,614	4	9	2	-	-	-
Tex.	357	39	78	-	51,429	50,277	60	36	2	16	-	16
MOUNTAIN	103	4	35	6	21,042	20,693	63	43	5	14	2	7
Mont.	-	-	-	-	588	849	2	3	-	-	-	-
Idaho	-	-	-	-	716	994	1	1	-	-	-	-
Wyo.	-	-	1	-	499	590	-	2	-	-	-	-
Colo.	45	-	6	2	6,059	5,828	8	2	2	11	-	2
N. Mex.	12	2	3	-	2,443	2,477	12	3	-	-	-	-
Ariz.	26	1	12	-	6,242	5,647	27	23	1	2	-	1
Utah	12	1	10	4	974	1,008	5	2	1	-	2	3
Nev.	8	-	3	-	3,521	3,300	8	7	1	1	-	1
PACIFIC	1,559	67	171	17	99,695	87,850	248	168	26	61	4	191
Wash.	80	4	13	-	7,464	6,579	15	17	3	2	-	34
Oreg.	27	1	1	-	4,999	5,089	49	17	3	-	-	3
Calif.	1,431	52	134	17	83,542	72,550	183	132	20	59	3	135
Alaska	3	-	23	-	2,323	2,153	-	1	-	-	1	-
Hawaii	18	10	-	-	1,367	1,479	1	1	-	-	-	19
Guam	1	U	-	-	119	188	U	U	U	U	U	3
P.R.	68	5	5	2	2,514	2,676	-	2	-	-	-	2
V.I.	2	-	-	-	348	421	1	1	3	-	-	-
Pac. Trust Terr.	-	U	-	-	146	-	U	U	U	U	U	20

N: Not notifiable

U: Unavailable

TABLE III. (Cont'd.) Cases of specified notifiable diseases, United States, weeks ending  
October 5, 1985 and October 6, 1984 (40th Week)

Reporting Area	Malaria		Measles (Rubeola)				Menin- gococcal infections		Mumps		Pertussis			Rubella		
			Indigenous		Imported *		Total									
	Cum. 1985		1985	Cum. 1985	1985	Cum. 1985	Cum. 1984	Cum. 1985	1985	Cum. 1985	1985	Cum. 1985	Cum. 1984	1985	Cum. 1985	Cum. 1984
UNITED STATES	777		5	2,064	-	431	2,349	1,840	31	2,320	99	2,177	1,883	3	559	623
NEW ENGLAND	45	-	38	-	88	105	86	-	54	31	144	53	-	12	18	
Maine	4	-	-	-	1	-	3	-	6	2	13	2	-	-	1	
N.H.	4	-	-	-	-	36	14	-	9	27	66	8	-	2	1	
Vt.	1	-	-	-	-	7	10	-	2	-	3	23	-	-	-	
Mass.	21	-	34	-	84	48	14	-	16	2	41	14	-	6	16	
R.I.	5	-	-	-	-	-	14	-	14	-	14	2	-	-	-	
Conn.	10	-	4	-	3	14	31	-	7	-	7	4	-	4	-	
MID ATLANTIC	126	1	172	-	38	152	327	-	254	10	140	154	-	218	216	
Upstate N.Y.	42	-	71	-	13	36	125	-	134	7	67	89	-	17	99	
N.Y. City	47	1	58	-	12	104	59	-	32	-	19	7	-	178	99	
N.J.	14	-	17	-	10	7	49	-	34	-	7	11	-	9	17	
Pa.	23	-	26	-	3	5	94	-	54	3	47	47	-	14	1	
E.N. CENTRAL	39	-	435	-	89	695	317	6	850	6	454	453	-	29	84	
Ohio	8	-	-	-	54	9	104	1	252	5	81	68	-	-	2	
Ind.	4	-	55	-	2	3	43	-	37	-	135	225	-	1	5	
Ill.	6	-	286	-	9	179	71	2	186	1	30	25	-	12	49	
Mich.	15	-	37	-	23	464	71	3	293	-	41	28	-	15	20	
Wis.	6	-	57	-	1	40	28	-	82	-	167	107	-	1	8	
W.N. CENTRAL	27	-	1	-	10	47	93	1	71	26	175	114	-	19	35	
Minn.	11	-	-	-	6	38	24	-	1	1	78	14	-	2	4	
Iowa	2	-	-	-	-	-	8	-	1	13	22	28	10	1	1	
Mo.	5	-	-	-	2	4	36	1	12	-	27	18	-	7	-	
N. Dak.	2	-	-	-	-	-	4	-	3	-	9	-	-	2	3	
S. Dak.	1	-	-	-	-	-	3	-	-	-	2	9	-	-	-	
Nebr.	1	-	-	-	-	-	-	-	2	3	7	11	-	-	-	
Kans.	5	-	1	-	-	5	11	-	40	-	24	52	-	7	27	
S. ATLANTIC	92	-	270	-	30	53	361	3	216	4	323	191	-	55	23	
Del.	-	-	-	-	-	-	8	-	1	-	1	2	-	1	-	
Md.	22	-	96	-	9	22	51	-	28	-	131	59	-	6	1	
D.C.	5	-	9	-	1	8	6	-	-	-	1	-	-	-	-	
Va.	19	-	21	-	7	5	45	-	42	3	17	19	-	2	-	
W. Va.	2	-	31	-	2	-	8	-	59	-	4	11	-	9	-	
N.C.	8	-	9	-	-	-	51	-	13	1	24	32	-	1	-	
S.C.	-	-	-	-	3	1	34	2	9	-	2	2	-	3	-	
Ga.	7	-	8	-	-	1	59	-	28	-	86	14	-	4	2	
Fla.	29	-	96	-	8	16	99	1	36	-	57	52	-	29	20	
E.S. CENTRAL	9	-	-	-	7	6	84	1	28	6	48	14	-	3	12	
Ky.	3	-	-	-	5	1	9	-	8	-	8	2	-	3	6	
Tenn.	-	-	-	-	1	2	32	1	16	-	19	7	-	-	-	
Ala.	5	-	-	-	-	3	25	-	1	6	17	1	-	-	3	
Miss.	1	-	-	-	1	-	18	-	3	-	4	4	-	-	3	
W.S. CENTRAL	75	-	416	-	15	534	154	4	247	-	328	287	1	34	54	
Ark.	3	-	-	-	-	8	15	-	6	-	14	18	-	1	3	
La.	1	-	42	-	-	8	23	-	2	-	12	8	-	-	-	
Okla.	4	-	-	-	1	8	29	N	N	-	134	237	-	1	-	
Tex.	67	-	374	-	14	510	87	4	239	-	168	24	1	32	51	
MOUNTAIN	43	-	496	-	51	145	77	5	218	2	171	107	-	5	21	
Mont.	-	-	122	-	17	-	5	2	11	-	9	19	-	-	-	
Idaho	2	-	126	-	18	23	2	-	9	-	5	7	-	1	1	
Wyo.	1	-	4	-	-	-	6	-	2	-	-	6	-	-	2	
Colo.	13	-	6	-	7	6	22	1	19	1	66	35	-	-	2	
N. Mex.	14	-	1	-	5	88	8	N	N	-	12	8	-	2	1	
Ariz.	8	-	237	-	4	1	19	2	108	1	34	23	-	1	4	
Utah	2	-	-	-	-	27	9	-	6	-	45	7	-	-	7	
Nev.	3	-	-	-	-	-	6	-	63	-	-	2	-	1	4	
PACIFIC	321	4	236	-	103	612	341	11	382	14	394	510	2	184	160	
Wash.	23	-	31	-	39	140	60	2	33	-	67	294	-	14	1	
Oreg.	12	-	4	-	1	-	31	N	N	-	40	25	-	1	2	
Calif.	269	4	183	-	58	309	238	8	322	14	241	118	2	126	152	
Alaska	2	-	-	-	-	-	8	1	9	-	29	1	-	1	1	
Hawaii	15	-	18	-	5	163	4	-	18	-	17	72	-	42	4	
Guam	1	U	10	U	1	90	-	U	5	U	-	-	U	2	4	
P.R.	-	-	63	-	-	14	12	-	138	-	10	1	-	25	11	
V.I.	-	-	4	-	6	-	-	-	3	-	-	-	-	-	-	
Pac. Trust Terr.	-	U	-	U	-	-	-	U	3	U	-	-	U	-	-	

\*For measles only, imported cases includes both out-of-state and international importations.

N Not notifiable U Unavailable †International §Out-of-state



**TABLE III. (Cont'd.) Cases of specified notifiable diseases, United States, weeks ending  
October 5, 1985 and October 6, 1984 (40th Week)**

Reporting Area	Syphilis (Civilian) (Primary & Secondary)		Toxic- shock Syndrome	Tuberculosis		Tula- remia	Typhoid Fever	Typhus Fever (Tick-borne) (RMSF)	Rabies, Animal
	Cum. 1985	Cum. 1984	1985	Cum. 1985	Cum. 1984	Cum. 1985	Cum. 1985	Cum. 1985	Cum. 1985
UNITED STATES	19,560	21,501	8	16,285	16,311	129	281	601+21	4,114
NEW ENGLAND	452	405	1	544	485	3	11	8+1	20
Maine	13	5	-	39	21	-	-	-	-
N.H.	36	12	-	15	25	-	-	1	1
Vt.	5	1	-	6	7	-	-	-	1
Mass.	225	231	1	328	267	3	8	61	11
R.I.	14	16	-	42	37	-	-	1	-
Conn.	159	140	-	114	128	-	3	-	7
MID ATLANTIC	2,724	2,926	-	2,972	2,961	2	42	32+1	421
Upstate N.Y.	211	251	-	523	465	-	11	9	98
N.Y. City	1,641	1,804	-	1,433	1,197	1	23	4	-
N.J.	538	505	-	401	665	1	7	4	35
Pa.	334	366	-	615	634	-	1	151	288
E.N. CENTRAL	786	1,027	1	2,004	2,107	2	32	40	148
Ohio	115	188	-	352	384	-	8	28	27
Ind.	71	109	1	246	251	-	3	4	21
Ill.	381	357	-	868	880	1	13	6	28
Mich.	169	310	-	424	460	-	6	2	22
Wis.	50	63	-	114	132	1	2	-	50
W.N. CENTRAL	175	292	-	449	506	38	12	40+2	753
Minn.	36	80	-	95	84	1	6	-	150
Iowa	17	11	-	48	55	-	2	1	130
Mo.	92	149	-	219	252	24	3	62	39
N. Dak.	2	9	-	8	11	-	-	1	107
S. Dak.	5	-	-	22	18	8	-	2	257
Nebr.	6	11	-	11	27	2	1	3	31
Kans.	17	32	-	46	59	3	-	27	39
S. ATLANTIC	4,957	6,301	-	3,286	3,428	6	31	289+12	1,072
Del.	29	14	-	28	45	1	-	3	1
Md.	344	395	-	281	327	-	11	26	539
D.C.	265	251	-	128	140	-	-	-	-
Va.	226	331	-	287	344	1	3	18	143
W. Va.	18	14	-	87	106	-	-	1	24
N.C.	528	642	-	415	490	4	4	1234	11
S.C.	631	603	-	409	409	-	1	691	59
Ga.	-	1,089	-	556	547	-	2	437	158
Fla.	2,916	2,962	-	1,095	1,020	-	10	6	137
E.S. CENTRAL	1,703	1,516	-	1,435	1,513	7	4	62+3	211
Ky.	54	79	-	346	357	-	1	101	27
Tenn.	490	401	-	413	450	5	1	302	65
Ala.	496	489	-	433	457	1	2	13	114
Miss.	663	547	-	243	249	1	-	9	5
W.S. CENTRAL	4,735	5,259	3	2,060	1,905	49	25	113+2	684
Ark.	244	167	-	207	206	29	-	14	111
La.	832	949	-	303	261	-	-	2	16
Okla.	145	170	1	205	175	15	2	81	88
Tex.	3,514	3,973	2	1,345	1,263	5	23	162	469
MOUNTAIN	556	474	2	421	446	14	11	14	345
Mont.	6	3	-	46	17	4	-	6	161
Idaho	6	21	-	21	26	-	-	-	9
Wyo.	8	7	-	5	-	-	-	4	18
Colo.	137	125	2	49	54	2	4	2	21
N. Mex.	106	63	-	73	87	2	4	-	11
Ariz.	251	162	-	189	203	4	3	-	112
Utah	5	18	-	12	31	2	-	-	4
Nev.	37	75	-	26	28	-	-	2	9
PACIFIC	3,472	3,301	1	3,114	2,960	8	113	3	460
Wash.	80	124	-	192	148	-	1	-	4
Oreg.	79	88	1	103	120	1	5	-	4
Calif.	3,259	3,025	-	2,593	2,472	4	103	3	449
Alaska	2	5	-	81	51	3	-	-	3
Hawaii	52	59	-	145	169	-	4	-	-
Guam	2	-	U	30	43	-	-	-	-
P.R.	651	639	-	291	292	-	2	-	32
V.I.	3	8	-	1	4	-	52	-	-
Pac. Trust Terr.	13	-	U	16	-	-	-	-	-

U: Unavailable

**TABLE IV. Deaths in 121 U.S. cities,\* week ending  
October 5, 1985 (40th Week)**

Reporting Area	All Causes, By Age (Years)						P&I** Total	Reporting Area	All Causes, By Age (Years)						P&I** Total	
	All Ages	≥65	45-64	25-44	1-24	<1			All Ages	≥65	45-64	25-44	1-24	<1		
NEW ENGLAND	627	430	136	39	13	9	41	S. ATLANTIC	1,189	740	260	96	34	59	49	
Boston, Mass.	143	85	38	16	2	2	12	Atlanta, Ga. §	139	124	1	5	3	6	2	
Bridgeport, Conn.	51	35	13	1	1	1	3	Baltimore, Md.	236	130	59	26	8	13	1	
Cambridge, Mass.	18	14	3	1	-	-	1	Charlotte, N.C.	56	31	16	4	2	3	3	
Fall River, Mass.	26	23	2	-	-	1	-	Jacksonville, Fla.	101	68	17	8	3	5	4	
Hartford, Conn.	43	27	12	4	-	-	2	Miami, Fla.	113	65	27	10	6	5	7	
Lowell, Mass.	25	21	2	1	1	-	3	Norfolk, Va.	70	43	19	4	-	4	8	
Lynn, Mass.	13	10	2	1	-	-	-	Richmond, Va.	84	44	23	10	-	7	6	
New Bedford, Mass.	29	23	5	1	-	-	3	Savannah, Ga.	38	26	6	3	-	3	4	
New Haven, Conn.	45	32	8	4	1	-	-	St. Petersburg, Fla.	92	78	7	2	1	4	6	
Providence, R.I.	66	58	6	-	1	1	6	Tampa, Fla.	68	39	18	3	5	3	3	
Somerville, Mass.	11	8	2	-	1	-	1	Washington, D.C.	164	72	64	18	4	6	5	
Springfield, Mass.	41	25	10	4	-	2	1	Wilmington, Del.	28	20	3	3	2	-	-	
Waterbury, Conn.	44	24	16	2	2	-	3									
Worcester, Mass.	72	45	17	4	4	2	6									
MID ATLANTIC	2,476	1,597	535	219	70	54	102	E.S. CENTRAL	834	521	208	61	20	24	41	
Albany, N.Y.	35	26	5	1	1	2	2	Birmingham, Ala.	128	76	33	10	7	2	3	
Allentown, Pa.	14	10	4	-	-	-	-	Chattanooga, Tenn.	67	49	15	3	-	-	4	
Buffalo, N.Y.	91	60	22	6	1	2	6	Knoxville, Tenn.	86	51	28	3	-	4	3	
Camden, N.J.	40	30	7	2	1	-	1	Louisville, Ky.	97	65	23	4	-	5	2	
Elizabeth, N.J.	32	25	4	2	-	-	-	Memphis, Tenn.	244	147	63	24	6	4	24	
Erie, Pa.†	44	28	9	2	3	2	3	Mobile, Ala.	65	38	12	5	4	6	3	
Jersey City, N.J.	45	26	11	6	2	-	4	Montgomery, Ala.	37	27	4	3	2	1	-	
N.Y. City, N.Y.	1,251	791	260	139	30	31	38	Nashville, Tenn.	110	68	30	9	1	2	2	
Newark, N.J.	61	28	21	6	2	4	2	W.S. CENTRAL	1,294	868	223	93	62	48	57	
Paterson, N.J.	37	21	11	3	2	-	1	Austin, Tex.	50	27	13	6	2	2	4	
Philadelphia, Pa.	396	242	110	24	14	6	20	Baton Rouge, La.	45	24	12	4	3	2	3	
Pittsburgh, Pa.†	87	58	20	4	3	2	1	Corpus Christi, Tex. §	46	44	-	1	-	1	-	
Reading, Pa.	26	23	3	-	-	-	5	Dallas, Tex.	200	109	44	27	9	11	5	
Rochester, N.Y.	102	75	11	9	5	2	7	El Paso, Tex.	52	31	13	2	4	2	2	
Schenectady, N.Y.	26	19	4	3	-	-	2	Fort Worth, Tex.	75	40	20	7	4	4	6	
Scranton, Pa.†	35	27	5	2	1	-	-	Houston, Tex. §	298	261	3	7	17	10	6	
Syracuse, N.Y.	70	50	10	2	5	3	2	Little Rock, Ark.	66	39	17	4	3	3	10	
Trenton, N.J.	30	18	7	5	-	-	1	New Orleans, La.	128	76	32	11	6	3	-	
Utica, N.Y.	24	17	4	3	-	-	3	San Antonio, Tex.	161	98	39	13	9	2	13	
Yonkers, N.Y.	30	23	7	-	-	-	4	Shreveport, La.	70	44	14	6	2	4	4	
								Tulsa, Okla.	103	75	16	5	3	4	4	
E.N. CENTRAL	2,262	1,627	365	128	64	77	103	MOUNTAIN	589	393	113	43	18	22	29	
Akron, Ohio	88	64	15	4	2	3	-	Albuquerque, N.Mex.	68	44	16	4	3	1	4	
Canton, Ohio	52	42	10	-	-	-	6	Colorado Springs, Colo.	34	19	7	4	3	1	3	
Chicago, Ill. §	553	462	11	26	16	37	16	Denver, Colo.	109	74	15	9	4	7	4	
Cincinnati, Ohio	120	72	32	9	4	3	9	Las Vegas, Nev.	71	46	20	3	1	1	2	
Cleveland, Ohio	143	85	39	10	8	1	3	Ogden, Utah	16	14	2	-	-	-	2	
Columbus, Ohio	127	94	21	9	1	2	2	Phoenix, Ariz.	114	73	26	9	3	3	5	
Dayton, Ohio	120	82	29	7	1	1	4	Pueblo, Colo.	22	21	-	1	-	-	1	
Detroit, Mich.	261	159	61	25	9	7	9	Salt Lake City, Utah	48	29	9	7	1	2	-	
Evansville, Ind.	45	33	7	2	-	3	1	Tucson, Ariz.	107	73	18	6	3	7	8	
Fort Wayne, Ind.	59	42	11	1	4	1	3	PACIFIC	1,773	1,154	378	138	54	42	100	
Gary, Ind.	16	9	5	2	-	-	1	Berkeley, Calif.	12	11	-	-	1	-	-	
Grand Rapids, Mich.	53	43	8	1	-	1	6	Fresno, Calif.	71	46	12	6	6	1	12	
Indianapolis, Ind.	145	89	33	11	6	6	4	Glendale, Calif.	10	9	1	-	-	-	1	
Madison, Wis.	43	29	6	5	1	2	3	Honolulu, Hawaii	70	49	13	5	1	2	8	
Milwaukee, Wis.	138	106	22	2	3	5	12	Long Beach, Calif.	77	50	24	1	1	1	6	
Peoria, Ill.	47	30	12	2	1	2	4	Los Angeles, Calif.	531	338	115	50	16	5	15	
Rockford, Ill.	47	35	8	3	1	-	4	Oakland, Calif.	78	53	16	3	4	2	5	
South Bend, Ind.	30	23	4	3	-	-	2	Pasadena, Calif.	43	31	9	1	-	2	3	
Toledo, Ohio	110	75	22	6	6	1	13	Portland, Ore.	93	60	21	7	4	1	2	
Youngstown, Ohio	65	53	9	-	1	2	1	Sacramento, Calif.	121	78	30	7	3	3	13	
W.N. CENTRAL	670	464	124	31	24	27	41	San Diego, Calif.	124	81	23	10	5	5	11	
Des Moines, Iowa	57	43	9	2	1	2	2	San Francisco, Calif.	156	90	35	21	1	9	4	
Duluth, Minn.	27	21	3	2	1	-	1	San Jose, Calif.	145	93	34	10	6	2	6	
Kansas City, Kans.	31	24	1	2	2	2	2	Seattle, Wash.	141	96	31	9	3	2	2	
Kansas City, Mo.	108	69	20	9	6	4	6	Spokane, Wash.	45	26	9	3	1	6	6	
Lincoln, Neb.	35	30	3	1	-	1	-	Tacoma, Wash.	56	43	5	5	2	1	6	
Minneapolis, Minn.	69	43	18	1	4	3	1									
Omaha, Neb.	79	63	10	3	2	1	8									
St. Louis, Mo.	138	83	38	4	5	8	12									
St. Paul, Minn.	71	47	15	2	1	6	5									
Wichita, Kans.	55	41	7	5	2	-	4									
TOTAL	11,714	7,794	2,342	848	359	362	563									

\*Mortality data in this table are voluntarily reported from 121 cities in the United States, most of which have populations of 100,000 or more. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.

\*\* Pneumonia and influenza.

† Because of changes in reporting methods in these 3 Pennsylvania cities, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

‡ Total includes unknown ages.

§ Data not available. Figures are estimates based on average of past 4 weeks.

## Current Trends

### Deaths Associated with Fires, Burns, and Explosions — New Mexico, 1978-1983

The New Mexico Health and Environment Department (NMHED) examined fire-, burn-, and explosion-associated deaths occurring in the state during 1978-1983. Data were collected from death certificates recorded by the Vital Statistics Bureau of NMHED, death reports from the Office of the Medical Investigator (OMI), and fire-fatality reports from the New Mexico State Fire Marshal's Office. Included were all deaths caused unintentionally by fire and flames (E890-899), explosive material (E923), and hot substance or object, caustic or corrosive material, and steam (E924).<sup>\*</sup> Also included were fire-associated deaths by suicide (E958.1) and assault (E968.1) and of undetermined intent (E988.1). Rates were calculated using 1980 census data for New Mexico. Ninety-four percent of persons whose deaths were coded as above were residents of New Mexico.

During 1978-1983, 204 deaths in New Mexico were identified as caused by fires, burns, or explosions. Of these deaths (identified from all three sources) 196 (97%) were identified in the OMI records; 195 (96%) were identified through death certificates listing cause of death; and 94 (46%) were found in the Fire Marshal records.

The average annual crude mortality rate was 2.6 per 100,000 persons (Table 2). The sex- and age-adjusted death rate for American Indians was twice that for white, non-Hispanics; the rate for persons of Hispanic origin was slightly higher than that for white, non-Hispanics.

Mortality rates varied by age, sex, and urban or rural location as defined by Standard Metropolitan Statistical Areas (SMSAs). The average annual age-adjusted death rate for males (4.0/100,000) was about three times that for females (1.4/100,000). Age-specific mortality rates were similar for males and females up to 14 years of age. Among persons older than 14 years, rates were higher for males than for females, with the highest rates for persons over age 75 years. The average annual death rate in the urbanized SMSAs (1.5/100,000) was 45% of that outside SMSAs (3.3/100,000).

Thirty (15%) of the New Mexico deaths occurred in the workplace, compared with 5%-6% nationally (1). Of the 30, 14 (47%) were caused by gas explosions (Table 3). Fires or explosions involving homes, mobile homes or other structures accounted for 119 deaths. Thirty-two (27%) of these deaths in homes or other structures occurred in mobile and trailer homes, which account for only 12% of year-round housing in New Mexico.

<sup>\*</sup>Based on International Classification of Diseases, 9th Revision. Supplementary Classification of External Cause of Injury.

**TABLE 2. Adjusted annual mortality rates\* from fires, burns, and explosions, by ethnicity — New Mexico, 1978-1983**

Ethnicity	Deaths		Rate ratio
	No.	Rate	
White, non-Hispanic	107	2.3	1.0
Hispanic	73	2.9	1.2
American Indian	22	4.6	2.0
Other	2	—	
<b>Total</b>	<b>204</b>	<b>2.6</b>	

<sup>\*</sup>Per 100,000 persons and adjusted to the age and sex distribution of 1980 New Mexico population.

*Fire-Associated Deaths — Continued*

Although not shown here, work-related deaths were equally distributed throughout the year; however, the frequency of nonwork-related deaths during winter months was twice that observed for the summer months.

Cigarette smoking, use of natural or propane gas, and alcohol consumption all contributed to fire-related deaths in New Mexico. Thirty-nine (19%) fire-related deaths were associated with cigarette smoking. Use of natural or propane gas was associated with 30 (15%) deaths. Blood alcohol concentrations (BAC) were measured at hospital admission or autopsy for 128 persons 10 years of age or older; 55 (43%) persons had BACs of 0.1 mg/dl or greater.

*Reported by GA Conway, MD, formerly of the University of New Mexico School of Medicine, J Smialek, MD, M Starr, Office of the Medical Investigator, Albuquerque, T Langhorst, New Mexico State Fire Marshal's Office, T Ortiz, HF Hull, MD, State Epidemiologist, New Mexico Health and Environment Dept; Div of Injury Epidemiology and Control, Center for Environmental Health, CDC.*

**Editorial Note:** The distribution of fire-, burn-, and explosion-related death rates by the age and sex of the victim in New Mexico is similar to that seen nationally (2,3). Rates are highest for males, preschool-aged children, and persons over 75 years of age. In addition, the seasonal distribution of deaths is consistent with national patterns. Home fires occur more frequently during winter months when heating is required and more time is spent indoors.

The New Mexico findings show an increased risk of fire-, burn-, and explosion-related deaths among American Indians, compared with that of other racial or ethnic groups. However, the risk for this group is similar to that for persons outside SMSAs. Ninety-five percent of fire-related deaths among American Indians in New Mexico occurred outside SMSAs. Reasons for this increased risk for fire fatality outside SMSAs may include decreased availability and response of fire department services, decreased likelihood of early discovery, less safe structures, and greater use of unsafe heating methods (2).

New Mexico has one of the lowest rates of mortality from house fires (2), possibly because of widespread use of materials other than wood, especially adobe, in home construction. In contrast, persons living in mobile homes in New Mexico have an increased risk of death from fires. Further study of mobile home dwellers would help identify risk factors and

**TABLE 3. Deaths from fires, burns, and explosions — New Mexico, 1978-1983**

Situation	Deaths
Work-related	
Gas explosion	14
Oil refinery or well explosion or fire	4
Gas station fire	3
Mine explosion or fire	2
Fall into incinerator	2
Other	5
Subtotal	30
Nonwork-related	
House or other structure fire or explosion	119
Kitchen fire	3
Bedding fire	13
Clothing fire	22
Camping fire	1
Stationary auto fire or explosion	3
Scalding	9
Subtotal	170
Unknown	4
<b>Total</b>	<b>204</b>

*Fire-Associated Deaths — Continued*

would, therefore, help target prevention programs. House-fire fatalities could be reduced by proper installation and maintenance of smoke detectors, regardless of structure type (4-6).

New Mexico has developed a model reporting system for injury surveillance based on collaboration between the state health department and organizations not often recognized as partners in public health. The OMI and Fire Marshal data provided important details surrounding the cause of death and identified 12 fire-related deaths not found by death certificates alone. The OMI in New Mexico is one of the first state medical examiner's offices to develop a computerized data system. As more such offices become computerized, all mortality surveillance, including injury surveillance, should improve.

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## **Tuberculosis — United States, First 39 Weeks, 1985**

During the first 39 weeks of 1985, substantially more tuberculosis cases were reported to *MMWR* than would be expected based on morbidity trends in previous years. The 15,839 tuberculosis cases provisionally reported for the week ending September 28 represent a 0.4% decrease and 66 fewer cases than for the same period in 1984. However, in the first 39 weeks of 1984, an 8.6% decrease and 1,514 fewer cases were reported, compared to the same period in 1983. For much of 1984, the cumulative number of tuberculosis cases showed a 7%-9% decline over the previous year (Figure 2). Thus, for 1985, the decline from 1984 is less than expected, and, in recent weeks, there has been as much as a 1% increase in case reporting, compared with 1984. Based on final reporting for 1982 through 1984, the number of reported cases of tuberculosis declined an average of 1,706 cases (6.7%) per year.

The areas with the largest increases in cases provisionally reported for 1985 are New York City, California, Texas, upstate New York, Florida, and Massachusetts (Table 4). The area with the largest decrease is New Jersey.

*Reported by Div of Tuberculosis Control, Center for Prevention Svcs, CDC.*

**Editorial Note:** Over the past 3 decades, the number of tuberculosis cases per year in the United States increased on only three occasions. An increase in 1963 was due to more complete reporting of primary tuberculosis cases; in 1975, to changes in counting criteria; and in 1980, to an influx of Indochinese refugees (1). As in every year, a number of reporting areas show increased morbidity; the reasons vary by reporting area. Some reasons for 1985 reporting increases might include reporting artifact, expected fluctuations in secular trends, discrete

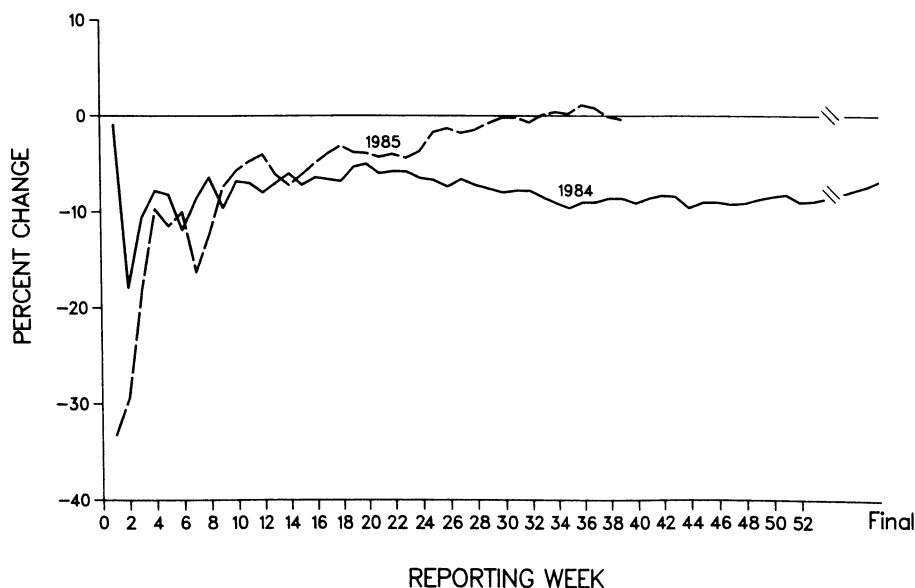
*Tuberculosis — Continued*

outbreaks (such as tuberculosis among the homeless) (2), an increased influx of foreign-born residents, or development of new risk factors. The decrease in New Jersey case reporting may be a reporting artifact commonly encountered during the first year of a state's participation in the national tuberculosis individual case reporting system; New Jersey began reporting to this system in 1985. CDC's Division of Tuberculosis Control is analyzing data from the newly implemented individual case reporting system to more precisely identify population groups experiencing increased morbidity. The Division is also working with state and local health departments to investigate factors related to increased morbidity. Data from New York City and Florida suggest that acquired immunodeficiency syndrome may be playing a role in the increased morbidity reported from these two areas (3,4). Investigations are continuing in New York City and Florida to evaluate the hypothesis that human T-lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV) infection may cause latent tuberculosis infection to become clinically active. If this hypothesis is correct, additional investigations will determine the extent to which the national morbidity may be attributed to HTLV-III/LAV infection.

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**FIGURE 2. Percent change from previous year of cumulative tuberculosis cases, by MMWR reporting week — United States, 1984 and 1985**



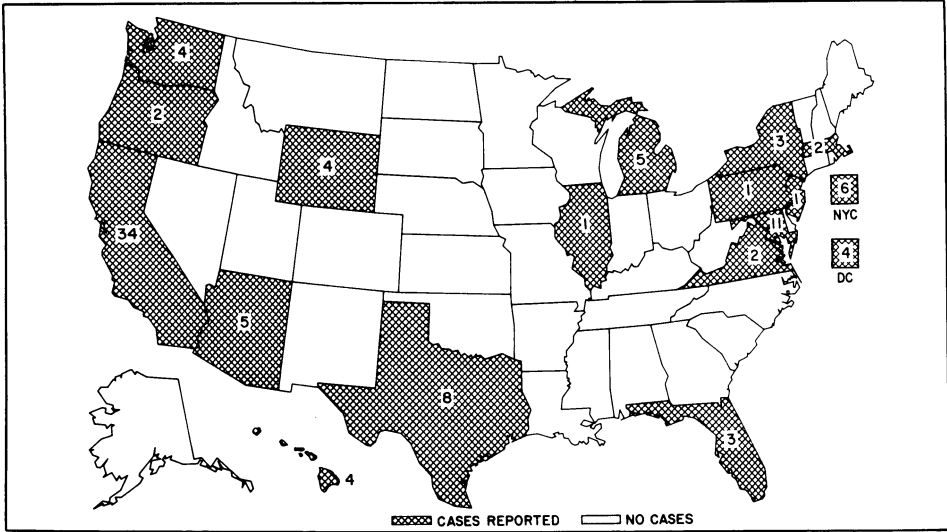
*Tuberculosis — Continued***TABLE 4. Tuberculosis cases reported to MMWR — United States, first 39 weeks, 1985 and 1984**

Area	Cases		Change		
	1985	1984	No.	Percent	Rank*
New York City	1,403	1,160	+243	+20.9	1
California	2,505	2,413	+92	+3.8	2
Texas	1,306	1,233	+73	+5.9	3
New York (upstate)	517	454	+63	+13.9	4
Florida	1,051	997	+54	+5.4	5
Massachusetts	315	262	+53	+20.2	6
Washington	191	145	+46	+31.7	7
Louisiana	303	261	+42	+16.1	8
Montana	46	17	+29	+170.6	9
Georgia	541	516	+25	+4.8	10
Alaska	72	51	+21	+41.2	11
Oklahoma	194	175	+19	+10.9	12
Maine	38	21	+17	+81.0	13
Minnesota	94	78	+16	+20.5	14
Mississippi	239	230	+9	+3.9	15
Arkansas	207	201	+6	+3.0	16
Wyoming	5	0	+5	†	17
South Dakota	22	18	+4	+22.2	18
Rhode Island	38	37	+1	+2.7	19
South Carolina	396	397	-1	-0.3	20
Vermont	5	7	-2	-28.6	21
Nevada	26	28	-2	-7.1	22
Colorado	49	52	-3	-5.8	23
North Dakota	7	11	-4	-36.4	24
Idaho	20	24	-4	-16.7	25
Iowa	46	50	-4	-8.0	26
Indiana	241	249	-8	-3.2	27
New Hampshire	15	25	-10	-40.0	28
Connecticut	113	123	-10	-8.1	29
Arizona	186	197	-11	-5.6	30
Illinois	844	855	-11	-1.3	31
New Mexico	73	85	-12	-14.1	32
Kentucky	336	348	-12	-3.4	33
Kansas	46	59	-13	-22.0	34
Nebraska	11	27	-16	-59.3	35
Delaware	28	45	-17	-37.8	36
District of Columbia	123	140	-17	-12.1	37
Oregon	98	116	-18	-15.5	38
Wisconsin	112	130	-18	-13.8	39
Utah	12	31	-19	-61.3	40
West Virginia	83	104	-21	-20.2	41
Hawaii	143	166	-23	-13.9	42
Alabama	421	446	-25	-5.6	43
Michigan	418	446	-28	-6.3	44
Missouri	214	247	-33	-13.4	45
Maryland	281	314	-33	-10.5	46
Ohio	345	380	-35	-9.2	47
Pennsylvania	586	623	-37	-5.9	48
Tennessee	400	447	-47	-10.5	49
Virginia	287	343	-56	-16.3	50
North Carolina	404	478	-74	-15.5	51
New Jersey	383	643	-260	-40.4	52
<b>United States</b>	<b>15,839</b>	<b>15,905</b>	<b>-66</b>	<b>-0.4</b>	<b>—</b>

\*Rank according to change in number of cases, 1985 compared with 1984.

†Indeterminable.

FIGURE I. Reported measles cases — United States, weeks 36-39, 1985



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The editor welcomes accounts of interesting cases, outbreaks, environmental hazards, or other public health problems of current interest to health officials. Such reports and any other matters pertaining to editorial or other textual considerations should be addressed to: ATTN: Editor, *Morbidity and Mortality Weekly Report*, Centers for Disease Control, Atlanta, Georgia 30333.

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